SURREY COMPREHENSIVE ORTHOPAEDICS

Mar 2020

Elective Referral Form

Date: DD/MM/YYYY

Central Booking Fax: 604-398-6356

Patient Information:

Name: *FIRST NAME MIDDLE INITIAL SURNAME*
PHN:
DOB: DD/MM/YYYY Gender: ☐M ☐F
Home Phone:
Cell Phone:
Address:
City: Postal Code:
Email:
WCB: ☐No ☐Yes → Claim #:
DOI: DD/MM/YYYY
Diabetic: ☐No ☐Yes → ☐Type 1 ☐Type 2 HbA1C: Date of test: DD/MM/YYYY

Referring Physician Information:

Name:
MSP#:
Phone:
Fax:
Address:
City: Postal Code:
Email:
Has this patient been referred before? ☐No ☐Yes
Name of previous orthopaedic surgeon:

Body Part:

☐Hand/Wrist/Elbow
☐Shoulder
☐Cervical Spine
☐Lumbar Spine
☐Knee
☐Knee (sports med)
☐Hip
☐Foot/Ankle

Side
☐Right
☐Left
☐Bilateral

Emergent Referrals:
Please contact the surgeon on call directly, or via the SMH Switchboard 604-581-2211

X-Ray Requirement: ****Please attach the requested X-ray reports**** or send patient for requested imaging at FHA. This referral CANNOT be properly triaged without x-ray reports unless exceptional circumstances are present.

☐Hand	(AP, Lateral)	☐Hip	(Standing AP Pelvis, True Lateral)
☐Wrist	(Neutral Rotation, PA & Lateral with Oblique)	☐Foot	(Standing AP, Lateral, Oblique)
☐Elbow	(AP, Lateral, Transolecranon)	☐Ankle	(Standing AP, Lateral, Mortise)
☐Shoulder	(AP Int Rotation, AP Ext Rotation, Axillary, Supraspinatus Outlet)	☐Lumbar Spine	(Standing AP, Lateral)
☐Knee	(Standing AP, Lateral, Skyline, Standing Notch)	☐Cervical Spine	(Upright AP, Lateral, Flex/Ext)

Reason for Referral:

Pertinent Clinical Information:

Next available surgeon?

☐ **YES**
☐ **NO - Select Specific Surgeon Below:**

☐BROWN	Knee, Hip
☐FROH	Knee, Hip, General Orthopaedics
☐JACKSON	Knee, Hip, Hand, Wrist, Elbow
☐LEE	Knee, Shoulder
☐MALOON	Spine*, General Orthopaedics
☐MATTHEW	Knee, Hip, Foot, Ankle
☐NADEAU	Knee,Spine*
☐NEUFELD	Knee, Hip
☐SCHWEIGEL	Knee, Hip
☐TELFER	Shoulder

***Spine Referrals:** please fill out the Spine Referral Form as well, located on our website